BEFORE THE PUBLIC UTILITIES COMMISSION OF THE STATE OF CALIFORNIA

Order Instituting Investigation on the Commission's Own Motion into the fatal accident on the Bay Area Rapid Transit District's Line between the Walnut Creek and Pleasant Hill Stations in the County of Contra Costa, California, on October 19, 2013.	**FILED** **PUBLIC UTILITIES COMMISSION** **JUNE 23, 2016** **SAN FRANCISCO** **I.16-06-010**

ORDER INSTITUING INVESTIGATION AND ORDER TO SHOW CAUSE WHY THE COMMISSION SHOULD NOT IMPOSE APPROPRIATE FINES AND SANCTIONS

I. INTRODUCTION AND STATEMENT OF PURPOSE

By this Order, the California Public Utilities Commission ("CPUC" or "Commission") institutes a formal investigation to determine whether the named Respondent, the Bay Area Rapid Transit District ("BART" or "District") repeatedly violated state codes and regulations (other than those occupational safety and health regulations alleged to be violated by the Division of Occupational Safety and Health ("DOSH") of the California Department of Industrial Relations in its Citation and Notification of Penalty dated April 17, 2014) by failing to provide adequate protection of BART's wayside workers and adequately train and control the Train Operator and Train Operator Trainer on Train # 963 on October 19, 2013, on BART's Pittsburg/Bay Point Line.

The Respondent is BART, a local government transportation agency composed of representatives from Alameda, Contra Costa, San Francisco, and San Mateo Counties. BART is subject to the safety oversight of the Commission. (Cal. Pub. Util. Code §§ 29047 and 49 C.F.R. § 659 et seq.) The Commission has jurisdiction over rail transit safety in the state of California, including safety oversight of Rail Fixed Guideway Systems and Light Rail Transit, pursuant to Public Utilities ("Pub. Util.") Code § 99152

and 49 C.F.R. Part 659 et seq. The Commission is the designated State Safety Oversight Agency ("SSOA") under 49 C.F.R. §§ 659 et seq.

The Commission has been regulating BART's rail fixed guideway system since 1973[1]. As a part of this oversight authority, Staff conducts regular inspections of BART's rail fixed guideway system, including its mechanical, track, signal, and operations departments.

By initiating this Order Instituting Investigation ("OII"), the Commission seeks to investigate and address BART's safety culture and accident prevention procedures. As the SSOA for BART, the Commission was a party to the accident investigation of the National Transportation Safety Board ("NTSB"). Under NTSB rules, parties to the NTSB investigation may not publish their own investigation report[2] until the NTSB issues its Accident Report.[3] The NTSB Accident Brief was not published until April 13, 2015, and the Commission Staff was not provided with a copy of the in-cab video of the accident until March 1, 2016. The Rail Transit Safety Branch of the Commission's Safety and Enforcement Division ("SED") issued its "Accident Investigation Final Report" on March 11, 2016.

II. BACKGROUND AND SUMMARY OF SED'S ACCIDENT INVESTIGATION FINAL REPORT

On Saturday, October 19, 2013, at approximately 1:44 p.m., a four car BART train, # 963, collided with two wayside workers on an at-grade section of the C1 track between the Walnut Creek and Pleasant Hill stations, resulting in fatal injuries to both. Train # 963 consisting of four cars was travelling Eastbound in non-revenue service since BART revenue service had been cancelled because of a labor dispute. The train was operating in Automatic Train Operation ("ATO") mode. A total of six persons were on-board: a transportation officer acting as a trainer, two train operator trainees, and

[1] D. 81248, 75 CPUC 166 (April 10, 1973).

[2] 49 C.F.R. § 831.13.

[3] *See*: NTSB/RAB-15-03 (April 13, 2015) at: http://www.ntsb.gov/investigations/AccidentReports/Pages/railroad.aspx .

three equipment maintenance personnel. The weather in Walnut Creek on October 19, 2014, was sunny with clear skies and the temperature was 70°F.

A. The Labor Strike

Prior to the accident, BART management and labor had been engaged in labor negotiations for several months. On Friday, October 18, 2013, BART unions called a strike, causing BART to discontinue revenue service. During the strike, trained management personnel performed essential system maintenance. Additionally, BART was preparing to open limited revenue service between Oakland and San Francisco. In meetings between BART and CPUC, BART had identified the personnel who would be allowed to perform safety-sensitive functions such as Train Control and Train Operation for both revenue and non-revenue trains, and provided their training and certification records.

B. Wayside Workers

Two wayside workers were on the tracks that Saturday, October 19, 2013. The two-man wayside crew consisted of a special project manager for BART's Tracks and Structures department and an independent consultant contractor. Both received a "Simple Approval" authorization from BART's Operations Control Center ("OCC") to enter the right-of-way between Walnut Creek and Pleasant Hill Stations at 1:05 p.m. "Simple Approval" authorizes access to the trackway without protection from moving trains and requires personnel to be aware of their surroundings and to provide their own protection from trains on the track. Any work performed within the trackway under Simple Approval requires a designated watchperson who must remain sufficiently outside the trackway so as not to be hit by a train.[4]

The two wayside workers proceeded to milepost 16.15 and began inspecting the track, using an aluminum rail gauge to take measurements. At 12:56, an Automatic Track Information System ("ATIS") message was broadcast indicating that no personnel were wayside throughout the BART system. After confirming the Simple

[4] Following this accident, BART issued an emergency suspension of the practice of "Simple Approval" on October 20, 2013, and permanently revoked the procedure on October 23, 2013, in response to this accident.

Approval, a second ATIS announcement was broadcast at 1:05 p.m., incorrectly indicating no personnel were present on the wayside. The OCC Operator quickly corrected the broadcast so that the presence of the two wayside workers was announced twice over the radio, once at 1:06 by the OCC Operator and a second announcement at 1:07 p.m. by ATIS. No further announcements regarding the workers' location were broadcast before the time of the incident, in violation of BART's rule requiring announcements at the top of each hour (:00) and the bottom of each hour (:30) during the presence of workers on the wayside.

C. The Collision

At approximately 1:44 p.m., the time of the accident, the Train Operator Trainee ("TOT") was operating the train at 65 miles per hour ("mph") and observed the two wayside workers standing in the middle of the trackway. The TOT applied emergency braking and, in an attempt to sound the horn to alert the wayside workers of an approaching train, instead depressed the door control button. Train # 963 was travelling at 56 mph when it made contact with the two wayside workers. The TOT immediately contacted OCC to announce the collision. OCC shut off traction power to the area at 1:47 p.m. and called the BART Police Department ("BPD") and the Contra Costa County Fire Department ("CCCFD"). BPD arrived at the scene approximately three minutes after the accident, established Incident Control, and quickly located the bodies of the two wayside workers. CCCFD took control of the scene at 1:58 p.m. and pronounced both workers deceased. BPD held the six employees onboard the train for approximately two hours to conduct interviews and perform post-accident drug and alcohol testing pursuant to 49 C.F.R. §§ 655.4 and 655.44.

D. Post-Accident Investigation

Following the accident, mechanical inspectors of the joint inspection team (NTSB, BART, CPUC, and DOSH) performed an on-site visual inspections of each car in the train consist starting with the lead car # 2528 and moving toward the tailing car # 397. The aluminum track gauge the two wayside workers had been using to measure the tracks was discovered lodged under car # 2528 on the right side. Car # 2528 sustained

damage to the left leaf of the front access door and to the lower right corner. No other defects were discovered at that time. Track inspectors found no visible indications of track geometry defects that might have contributed to the collision. Investigators used train control data and the train's on-board data logger to obtain precise information regarding the train's position, speed, and mode of operation at the time just before and after the collision.

On Wednesday, October 23, 2013, investigators from NTSB, BART, CPUC, and DOSH participated in a series of full-scale tests reenacting the accident. The stopping distance of the test train between first application of brakes and the final resting place was determined to be 1,299 feet. The test train came to rest 69 feet beyond the point of impact of two mannequins placed between the two rails of the track at the point where the two wayside workers had been struck. Two additional reenactment tests were performed and in each case the test train came to a stop beyond the point of impact.

III. NTSB'S SPECIAL INVESTIGATION REPORT AND URGENT SAFETY NOTICES

In the NTSB's "Special Investigation Report" of September 24, 2014, NTSB/SIR-14/03, PB2015-100583, the NTSB noted that were no federal regulations applicable to rail transit agencies to help ensure that the roadway worker has a safe work environment or to guide rail transit agencies in developing safety programs, rules, and procedures for roadway workers. The Report stated:

> The trainee told NTSB investigators that as train 963 was exiting a curve (CT-137 15.630 to 15.990) onto a section of straight track about 248 feet long, he thought that he saw something ahead but was not sure if employees were in the track. As the train continued north, the trainee realized there were people on the track and applied the emergency brake (hit the red mushroom button on the control panel). He said he also screamed, "No! No! No!" and was attempting to press the horn button with his other hand. He said he knew the train was going to hit the employees if they did not get out of the track.
>
> The operator trainer/supervisor said that he heard the trainee's scream and went closer to the operator compartment. The

> trainee stated he thought the time from when he applied the brake to the impact with the employees in the right-of-way was about 10 seconds. He said that he sounded the horn after placing the train into emergency braking and that the train neared the employees' location and struck the two employees in the track about MP 16.15. This location was in the spiral portion of a curve. The train stopped in the curve several hundred feet past the point of impact. The trainee called the train controller and told him that the train had struck two employees.

(NTSB's "Special Investigation Report" at pp. 24 – 25.)

On December 18, 2013, the NTSB made the following urgent safety recommendations to the Federal Transit Administration ("FTA") to prevent further accidents on BART and other rail transit systems without delay:

> R-13-39 (Urgent)
>
> Issue a directive to all transit properties requiring redundant protection for roadway workers, such as positive train control, secondary warning devices, or shunting.
>
> R-13-40 (Urgent)
>
> Issue a directive to require all transit properties to review their wayside worker rules and procedures and revise them as necessary to eliminate any authorization that depends solely on the roadway worker to provide protection from trains and moving equipment.

(*Id*. at p. 29; *see also*: NTSB Railroad Accident Brief (April 13, 2015) at p. 3.)

IV. THE FEDERAL TRANSIT ADMINISTRATION'S SAFETY ADVISORY 14-1

Shortly after the NTSB's urgent safety recommendations to the FTA, the FTA issued its "Safety Advisory 14-1: Right-of-Way Worker Protection" (December 2014). The FTA Safety Advisory provided that the State Safety Oversight agencies coordinate with the rail transit agencies in their jurisdiction to complete the following:

- Inventory current practices, including the identification of the rules, procedures, technology and other elements currently in place to protect ROW workers. This request can be addressed by completing Appendix 1 of

this advisory and submitting it to the FTA by **close of business on February 28, 2014**. Instructions are provided in Attachment 1.

- Conduct a formal hazard analysis regarding workers' access to the ROW and how the protections identified in the inventory address the consequences associated with each hazard. This analysis is due to the FTA by **close of business on Friday, May 16, 2014**.

("Safety Advisory 14-1: Right-of-Way Worker Protection" at pp. 1 – 2.)

The FTA also noted that "[t]he NTSB has recommended that redundant protection be used when workers are on the ROW under their own protection, including "lock outs" from the train control systems, secondary warning devices and alert systems, and shunt devices to prohibit trains from entering locations with workers on the ROW." (*Id*. at p. 6.) The FTA pointed out that "Rail transit agencies that have experienced multiple worker fatalities have determined that it should never be left solely to the discretion of work crews to determine if critical protections are needed at specific work sites, such as a request for speed restrictions on approach to a specific station or mile marker, or an authorization to put shunts in, or the assignment of an extra watch, or even the re-scheduling of work." (*Id*. at p. 8.)

V. THE DIVISION OF OCCUPATIONAL SAFETY AND HEALTH ENFORCMENT CITATIONS AND PENALTIES

DOSH, a Division of the California Department of Industrial Relations, investigated the accident and issued its Citation and Notification of Penalties on April 17, 2014.

A. DOSH Citation and Penalty No. 1

DOSH cited BART for a violation of Title 8, Code of California Regulations ("C.C.R.") § 2944 (c) (1) on the grounds that BART "failed to ensure that only qualified electrical workers were allowed to perform work or take any conducting object within an area where there is a hazard of contact with energized conductors."[5] The

[5] "On October 19, 2013, while inspecting a section of the C1 railway track at milepost 16.1, an employee(s) who

Citation was deemed "Willful[6] Serious"[7] and the penalty imposed was $ 70,000.

B. DOSH Citation and Penalty No. 2

DOSH cited BART for a violation of 8 C.C.R. § 3203 (a) (7) (C) for BART's failure to "establish, implement and maintain an effective Injury and Illness Prevention Program." DOSH asserted that the Injury and Illness Prevention Program "was not effectively implemented with respect to the training provisions, in that the employer allowed employees, who had been given a new job assignment, to perform that job while having not completed the training." (DOSH Citation and Notification of Penalty (April 17, 2014) at p. 6.) "Moreover, employees that were assigned to be "Train Operators" on a regional rail rapid transit system were allowed to operate trains with inadequate supervision during an abbreviated training course. As a result, on October 19, 2013, two track workers were struck and killed by "Train 963" during work inspecting a section of the C1 railway track at milepost 16.1, while an untrained 'Train Operator' was at the controls." (*Ibid*.) The Citation was deemed "Willful Serious" and the penalty imposed was $ 70,000.

C. DOSH Citation and Penalty No. 3

DOSH cited BART for a violation of 8 C.C.R. § 3332 (b) for BART's failure to:

> develop and institute controls to safeguard personnel during railcar movement. The employer allowed workers to conduct work on the railway tracks where trains were travelling in excess of sixty-five (65) miles-per-hour. Employer's control method, namely the "Simple Approval" procedure, does not safeguard personnel working on tracks during railcar

---

was not a qualified electrical worker, was allowed to perform work and take a conducting object (aluminum "Track Gauge") within the area of the railway track that exposed the employee(s) to an energized 1000 Volt DC, "third-rail" conductor." (DOSH Citation and Notification of Penalty (April 17, 2014) at p. 5.)

[6] "The word 'willfully,' when applied to the intent with which an act is done or omitted, implies simply a purpose or willingness to commit the act, or make the omission referred to. It does not require any intent to violate law, or to injure another, or to acquire any advantage." (See: Cal. Penal Code § 7 as incorporated under Cal. Labor Code § 6425 (e).)

[7] "There shall be a rebuttable presumption that a 'serious violation' exists in a place of employment if the division demonstrates that there is a realistic possibility that death or serious physical harm could result from the actual hazard created by the violation…". (Cal. Labor Code § 6432.)

> movement. Provisions of the "Simple Approval" procedure that fail to safeguard employees include, but are not limited to, the employees being made responsible for their own safety and specifically not being notified of trains actively entering their work area. Furthermore, the requirement of the said procedure to post one of the employees working on the tracks as a "Watchperson" to warn of oncoming rail traffic was not implemented. As a result, on October 19, 2013, two track workers, while operating under the employer's "Simple Approval" procedure, were struck and killed by "Train 963" during work inspecting a section of the C1 railway track at milepost 16.1. (A) The employees had no warning that a train moving at more than 65 miles-per-hour was on the C1 railway track approaching the location where they were working. (B) Neither of the two track workers was performing the duties of the "Watchperson", as specified by the employer's "Simple Approval" procedure, at the time of the incident.

(DOSH Citation and Notification of Penalty (April 17, 2014) *supra*, at p. 7.)

The Citation was deemed "Willful Serious" and the penalty imposed was $ 70,000.

VI. PRELIMINARY FINDINGS

On March 11, 2016, the Rail Transit Safety Branch of the Commission's Safety and Enforcement Division ("SED") completed its "Accident Investigation Final Report on BART's October 19, 2013 Train Collision with Two Roadway Workers Between Walnut Creek and Pleasant Hill Stations". The SED Report is being served on BART concurrently with this OII and Order to Show Cause Why the Commission Should Not Impose Appropriate Fines and Sanctions ("OSC").

A. Wayside Workers

The evidence indicates that the two wayside workers failed to designate or properly implement BART's rule requiring "qualified [trained and certified] persons responsible for detecting approaching on-rail vehicles [to warn the wayside] crew pursuant to BART Rule 6217.

B. "Simple Approval"

While Staff contends that "Simple Approval" is generally dangerous[8] for reasons not relevant here, Staff has determined it was especially dangerous in this situation where the two wayside workers were engaged in measuring rail distances on the track with no watchman present. Since no revenue trains were operating on October 19, 2014, a Work Area Clearance could have been issued following the Operations Rules and Procedures ("OR&P") Manual, Section 6300, excluding all trains from this track area.

C. Operations Control Center

A BART Manager, operating as the Train Controller violated the OR&P, Rule 6215.F, by failing to announce that the roadway workers would provide their own protection. The Train Controller also violated the OCC Manual, Section 437B, by failing to broadcast the ATIS announcement describing the location of the roadway workers at or around 1:30 p.m. Further, repeating the announcement at the bottom of the hour would have reminded the crew of Train # 963 of the roadway workers' presence.

D. Train Crew

Due to the labor strike, the Train Operator ("TO") and Train Operator Trainiee ("TOTs") were not acting in their typical capacitites. The TO had worked previously as a BART train operator and an operator trainer, but was currently assigned to manage the transportation department on the C- and K-lines. At the time of the incident the TO, the only qualified TO on board Train # 963, was not behind the train controls. The TOT was operating the train controls at the time of the incident. According to TO's interview, he was not present in the operator's cabin at the time of the collision or the events leading up to the accident. Cellular telephone records indicate that

[8] On January 12, 2001, Staff responded to a fatal incident in which a BART electrician was struck and killed by a BART train in the underground M55 Interlocking (between 24th Street Station and 16th Street Station) in San Francisco, California. Staff found the accident "was apparently caused by failure to follow rules requiring employees to protect themselves from trains." On October 14, 2008, BART train # 381 struck and fatally injured a wayside worker. Staff's 2009 Accident Investigation Report on BART's recommends that BART "abolish" Simple Approval for wayside workers. These two BART wayside worker fatalities and the October 19, 2013 BART incident resulted in Staff questioning "whether rail transit districts within the State of California provide[d] adequate protections for roadway workers." *See*: *ORDER INSTITUTING RULEMAKING TO CONSIDER CALIFORNIA TRANSIT AGENCIES' ROADWAY WORKER PROTECTIONS* (Feb. 2, 2009), R.09-01-020 at pp.1 - 2.

he was using his device for text messaging and phone calls while simultaneously supervising the TOT, and repeatedly violated GO 172, Sections 3.1.a and 3.1.b., and BART's Use of Personal Electronic Device ("PED") Policy and the Operator's Rules and Procedures Manual, Rule 1334, by not stowing his device while supervising the TOT. Text messages sent by the TO and received less than five minutes prior to the approximate time of the accident, including one sent at 1:43 p.m., one minute prior to the BART train striking and killing the two wayside workers, may have distracted the TO from his supervisory duties regarding the TOT. Further, the TO's location away from the operator's chair combined with the distractions of his cellular telephone and the narrow windshield may have made proper observation and instruction very difficult.

The TOT operating the train at the time of the accident stated in his interview with NTSB that he had never been a revenue train operator for BART. Furthermore, the TOT was not included in BART's list of approved Train Operators who might operate limited transbay service during the strike which was provided to Staff before the accident. Finally, the TOT stated that he was aware of the Simple Approval in effect, and of the presence of roadway workers between Walnut Creek and Pleasant Hill Stations; however, it is evident that he lacked the necessary training and experience to act on this information in an appropriate and safe manner.

E. The In-Cab Incident Video

The BART Train Operator Certification Textbook advises train operators to hold the right hand over the stop button while pressing the horn button with the left hand when approaching stations. The TOT did not use the two-handed technique while performing station bypasses earlier in the day. Additionally, Staff found that the TOT failed to properly sound the horn in advance of the collision in violation of BART Train Operator Manual, Book 315, Rule 304.

VII. ORDER TO SHOW CAUSE AND PENALTIES

The NTSB's Accident Report and SED's Accident Investigation Final Report establish sufficient grounds for this Investigation and Order to Show Cause Why the Commission Should Not Impose Appropriate Fines and Sanctions ("OSC") for

violations of applicable safety rules and regulations. The "Simple Approval" procedure for BART wayside workers placed the burden of employee protection against collisions with trains on the personnel engaged-in and focused-on track work. The failure to advise and seek Commission Staff approval in the use of uncertified, untrained, and unapproved personnel to operate trains during an unusual period of BART operations, i.e., during a labor strike increased the dangers to wayside workers. Finally, the violations of applicable safety rules and regulations placed unknowing BART wayside workers in the direct path of a train operating at full speed and unable to stop before striking the workers. This OII and OSC places BART on notice and provides an opportunity for BART to be heard on the issue of whether it violated federal, state, and/or its own safety rules and regulations, the reasons BART failed to comply with its agreement to use only qualified TOs to operate trains during the strike, and whether penalties should be imposed. The OII provides the forum for BART to be heard and submit evidence, information, or documents on its behalf.

Pursuant to Pub. Util. Code sections 2107 and 2108, the Commission may impose penalties in the mount of $500 to $50,000 per day per offense for on-going violations of the Pub. Util. Code, and may consider other remedies under Pub. Util. Code § 701.

IV. PRELIMINARY SCOPING MEMO

The scope of the issues to be determined in the proceeding shall be (1) whether BART violated federal, state, and/or BART safety rules or regulations at or near the time of the accident on October 19, 2013, (2) whether the failure to correct the list of safety personnel who would operate BART trains during the labor strike, the failure to obtain Commission Staff approval prior to train operations during the strike, and the operation of BART trains by uncertified, untrained, and unapproved personnel during the strike served to mislead the Commission by artifice or false statement in such manner as to violate Rule 1.1 of the Commission's Rules of Practice and Procedure[9], and

[9] Title 20, California Code of Regulations, § 1.1 (Ethics).

(3) if Rule 1.1 was violated by BART's failure to obtain prior approval of the use of uncertified, untrained, and unapproved personnel to operate trains during the strike, whether BART should be fined or otherwise penalized for such violation.

Within 10 days of the mailing date of this order, Respondent shall file and serve a response to this OII and OSC. If more time is needed, Respondent shall meet and confer with Staff prior to requesting an extension from the Administrative Law Judge ("ALJ").

If a hearing is requested by respondent or other party, the assigned ALJ will set a hearing, and, if necessary, will set a schedule for further hearings and/or briefs. The Assigned Commissioner will issue a scoping memo setting forth the scope of the proceeding and establish a procedural schedule.

VIII. PROCEEDING CATEGORY AND NEED FOR HEARING

Rule 7.1 (c) of the Commission's Rules specifies that an "order instituting investigation shall determine the category of the proceeding [and] preliminarily determine the need for hearing." The Safety and Enforcement Division has determined that this proceeding is adjudicatory as defined in Rule 1.3 (a), and that evidentiary hearings may be necessary. The categorization is appealable under Rule 7.6 of the Commission's Rules of Practice and Procedure.

IX. EX PARTE COMMUNICATIONS PROHIBITED

Article 8 of the Commission's Rules of Practice and Procedure applies to all communications with decision makers and advisors regarding the issues in this proceeding. This proceeding is categorized as adjudicatory and Rule 8.3 (b) prohibits all *ex parte* communications.

Therefore, **IT IS ORDERED** that**:**

1. An Investigation is opened on the Commission's own motion for the purposes of investigating (a) the fatal accident that occurred on BART's Pittsburg/Bay Point Line on October 19, 2013, (b) whether BART violated federal, state, and/or BART safety rules or regulations at or near the time of the accident on October 19, 2013, and, if

so, whether fines or other penalties should be imposed, (c) whether the operation of BART trains by uncertified, untrained, and unapproved personnel contributed to the cause of the accident, (d) whether the failure to correct BART's list of safety personnel who would operate BART trains during the labor strike, and BART's failure to obtain Commission Staff approval prior to train operations during the strike, served to mislead the Commission by artifice or false statement in such manner as to violate Rule 1.1 of the Commission's Rules of Practice and Procedure, and (e) if Rule 1.1 was violated by BART's failure to obtain prior approval of the use of uncertified, untrained, and unapproved personnel to operate trains during the strike, whether BART should be fined or otherwise penalized for such violation.

2. The assigned Administrative Law Judge will set a hearing if needed. BART and any other interested party may show cause why the Commission should not impose a fine or penalty under Public Utilities Code §§ 309.7, 2101, 2104, 2107.5, 2113, 29047, GO 172, 99152, and GO 172.

3. Staff, BART, and any other interested party may present evidence and/or argument at the hearing on the order to show cause.

4. This proceeding shall be categorized as an adjudicatory proceeding pursuant to Rules 7.1 (d) of the Commission's Rules of Practice and Procedure.

5. All ex parte contacts are *prohibited* pursuant to Rules 8.3 (b).

6. The Executive Director shall cause a copy of this order and the Safety and Enforcement Division's Accident Investigation Final Report dated March 11, 2016, to be served upon the Respondent by certified mail.

///

///

///

Matthew Burrows, General Counsel
Bay Area Rapid Transit District
300 Lakeside Drive, 23rd Floor
Oakland, CA 94604-2688

Tom Radulovich, President
Bay Area Rapid Transit District
300 Lakeside Drive, 23rd Floor
Oakland, CA 94604-2688

Grace Crunican, General Manager
Bay Area Rapid Transit District
300 Lakeside Drive, 23rd Floor
Oakland, CA 94604-2688

This order is effective today.

Dated June 23, 2016, at San Francisco, California.

MICHAEL PICKER
President
MICHEL PETER FLORIO
CATHERINE J.K. SANDOVAL
CARLA J. PETERMAN
LIANE M. RANDOLPH
Commissioners